COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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AAA TUESDAY MAILING
June 10, 2003

1600 Forest Avenue, Suite 102, Richmond, Virginia 23229
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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Bill Peterson

DATE: June 10, 2003

SUBJECT: **Medicaid Preferred Drug List**

The 2003 state budget contains language that requires DMAS to implement cost containment strategies beginning in January 2004 for prescription drugs covered by Medicaid. To this end, DMAS is developing a preferred drug list (also known as a PDL). Attached is a memo from Jill Hanken of the Virginia Poverty Law Center to the Commonwealth Council on Aging which provides a preliminary overview of the PDL.

Attachment

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THE VIRGINIA POVERTY LAW CENTER
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(804) 782-9430 • FAX (804) 649-3746

Steven L. Myers, Executive Director
Janet Brown, Staff Attorney
Jill A. Hanken, Staff Attorney
Raymond Hartz, Staff Attorney
James W. Speer, Staff Attorney
Audrey V. Green, Training Coordinator

June 5, 2003

To: Commonwealth Council on Aging

From: Jill A. Hanken

Re: Medicaid Cost Containment – Pharmacy Coverage

2003 Budget Language Item 325 (Medicaid)

- Increases co-pay for brand name drugs from $2 to $3.

- Requires pre-authorization of prescription drugs when more than nine unique prescriptions have been prescribed within a 180 day period. [30 day period for nursing home residents.] Does not apply to residents of MR training centers or patients at Hiram Davis Medical Center.

- Requires DMAS to begin an initiative with pharmacies and physicians to encourage the use of over-the-counter products for non-sedating antihistamines

- Requires DMAS to implement a "Preferred Drug List" by January 2004. This will identify a specific list of drugs a Medicaid recipient can receive without prior authorization. A "Pharmacy and Therapeutics Committee" will assist in the development and administration of the PDL. The Committee will recommend exceptions for certain conditions/drugs and procedures for prior authorization, emergencies and existing drug regimens. Budget language requires consumer and provider training/education.

  Considerations: safety and clinical effectiveness, cost

  PDL program must generate savings of $9 million GF in FY 2004 and $18 million GF in subsequent years.

  PDL program may include "supplemental rebates" from drug manufacturers to achieve cost savings.

Implementation of PDL

- DMAS has selected Pharmacy and Therapeutics Committee
- RFP issued
- Input from stakeholders – pdlinput@dmas.state.va.us
- Will exclude various drugs used in the treatment of diabetes, Alzheimers, clotting disorders, HIV/AIDS, cancer, seizure disorders, mental health, transplant rejections, arthritis, nausea in cancer patients, serious mental illness.

Concerns of Consumers

- The proposal interferes with a doctor's medical judgment to prescribe a particular drug for a patient.
- The proposal imposes additional time/paperwork demands on doctors who want to prescribe certain drugs for their patients.
- The proposal imposes additional time/paperwork demands on pharmacists who must also "jump through the hoops" of prior authorization.
- The proposal only affects the Medicaid fee-for-service population, which is primarily composed of elderly and disabled recipients. This is a vulnerable population - most with chronic conditions that require ongoing drug therapy.
- Even a well-intentioned prior authorization system can become an administrative nightmare for patients, doctors and pharmacies.
- A drug prior authorization system often leaves patients without the drugs they require.
- Florida's experience in one month - Over 58,000 recipients were denied their medications due to Florida's four brand limit and the PDL; Approximately 25,000, or less than half, of these recipients eventually received the drug; Approximately 13,600 recipients received either a generic substitute or a different brand name; Over 20,000 recipients, or more than a third of all denials, failed to receive any medication in the same therapeutic class as the prescription. Litigation recently settled.
- By definition a Prior Authorization system makes it much more difficult to obtain access to drugs that are not on the preferred list. (That's how it saves money!)
- Doctors will routinely send patients to the pharmacy with a script for a PA-

only drug without having sought PA, with the consequence that the patient – who may have difficulty returning to the drug store – will not only fail to get the PA-only drug; they will walk out with NO drug at all.

- In addition, even those doctors who know a drug requires PA will be discouraged from requesting PA, because of the intrinsic administrative burden (i.e., keeping track of the changes in the formulary, filling out papers, making additional phone calls).

- DMAS/Provider relationships may suffer because doctors and pharmacies object to the additional administrative burden.

- Inevitably, there will be cases (perhaps thousands) where sick patients experience delays or denials of the drugs they need. This can lead to poor health and/or cost shifts such as unnecessary hospitalization.

Next Steps

Continue involvement in design of program – particularly prior authorization process. Goals:

Maintain access to medically necessary drugs

Minimum barriers/ simplified process to obtain medically necessary drugs

Saves money

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Janet L. Honeycutt

DATE: June 10, 2003

SUBJECT: **April 2003 Unmet Need Report**

Attached, please find the Unmet Need Report for April. If you see any discrepancies, please bring them to my attention.

Let me know if you have any questions.

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VIRGINIA DEPARTMENT FOR THE AGING
Unmet Demand for April, 2003

PSA	RCVD	Adult Day Care			Home Delivered Meals			Homemaker			Personal Care			Residential Repair			Transportation			PSA
		Unmet Demand (hours)	Persons Unserved	Persons Under-served	Unmet Demand (meals)	Persons Unserved	Persons Under-served	Unmet Demand (hours)	Persons Unserved	Persons Under-served	Unmet Demand (hours)	Persons Unserved	Persons Under-served	Unmet Demand (homes)	Persons Unserved	Persons Under-served	Unmet Demand (trips)	Persons Unserved	Persons Under-served	
1	*x*	1,351	6	6	14,766	205	341	12,795	362	138	3,105	38	21	126	136	17	5,087	273	212	*1*
2	*x*	234	1	3	14,215	68	341	7,024	194	4	386	0	119	198	198	0	33	4	11	*2*
3	*x*	0	0	0	43,332	265	833	6,509	77	162	1,695	18	14	62	15	29	0	0	0	*3*
4	*x*	0	0	0	11,133	0	271	8,578	135	159	0	0	0	0	0	0	1,497	13	63	*4*
5	*x*	432	0	5	94	0	31	288	13	11	254	13	0	0	0	0	0	0	0	*5*
6	*x*	0	0	0	14,274	136	679	0	0	0	0	0	0	0	0	0	30	3	0	*6*
7	*x*	0	0	0	174	2	16	116	6	0	0	0	0	0	0	0	0	0	0	*7*
8A	*x*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*8A*
8B	*x*	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	3	2	*8B*
8C	*x*	6,200	44	1	352	3	5	8	1	0	0	0	0	0	0	0	98	2	2	*8C*
8D	*x*	0	0	0	1,307	0	70	0	0	0	0	0	0	0	0	0	0	0	0	*8D*
8E	*x*	368	6	0	0	0	0	16	1	0	252	8	0	34	34	0	140	6	27	*8E*
9	*x*	960	12	0	1,347	0	125	26	0	5	358	2	30	8	8	0	3,078	0	143	*9*
10	*x*	22,900	19	5	500	18	16	547	15	1	610	19	1	4	4	0	0	0	0	*10*
11	*x*	0	0	0	339	76	17	36	10	0	0	0	0	0	0	0	59	0	59	*11*
12	*x*	0	0	0	27,146	30	667	537	9	126	1,973	8	95	8	11	0	123	7	30	*12*
13	*x*	1,543	2	18	420	0	17	7,442	110	100	0	0	0	0	0	0	0	3	126	*13*
14	*x*	0	0	0	1,288	23	0	2,880	0	90	0	0	0	0	0	0	0	0	0	*14*
15	*x*	208	2	0	0	0	0	485	18	0	42	1	0	28	24	4	29	6	0	*15*
16	*x*	0	0	0	0	0	0	208	52	0	0	0	0	4	5	0	0	0	0	*16*
17/18	*x*	1,504	7	6	1,473	6	68	954	11	31	6,206	71	38	9	7	2	2,347	84	203	*17/18*
19	*x*	90	0	4	180	0	5	2,190	0	30	0	0	0	0	0	0	20	0	10	*19*
20	*x*	0	0	0	0	0	0	528	8	10	144	6	0	0	0	0	164	82	0	*20*
21	*x*	352	9	1	3,322	151	0	0	0	0	8,029	57	136	0	0	0	2,314	109	2	*21*
22	*x*	0	0	0	401	21	0	0	0	0	130	3	2	26	20	6	0	0	0	*22*
TOTAL		36,142	108	49	136,063	1,004	3,502	51,167	1,022	867	23,184	244	456	507	462	58	15,029	595	890	TOTAL
ANNUAL		433,704			1,632,756			614,004			278,208			6,084			180,348			ANNUAL
# AAAs		25			25			25			25			25			25			# AAAs

This information is provided by Area Agencies on Aging.

The Department is not responsible for the accuracy of the data provided by the Area Agencies on Aging.

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: June 10, 2003

SUBJECT: **May 20, 2003 Testimony of Assistant Secretary Carbonell**

The entire eighteen page testimony of Secretary Carbonell before the Special Committee on Aging, United States Senate, is now available on: **www.aoa.dhhs.gov**. In her testimony, the Secretary discusses the Departments on Labor and Health and Human Services Report to Congress on Long-Term Care Workers. She also presents three priority initiatives of the Bush Administration to empower older persons and better support their preferences and needs. These initiatives involve rebalancing the long-term care system, health promotion/disease prevention activities and support for family caregivers.

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MEMORANDUM

TO: Executive Directors
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FROM: Bill Peterson

DATE: June 10, 2003

SUBJECT: **House GOP Leaders Agree On Medicare Drug Benefits**

House Republican leaders have agreed on the outlines of a plan to revamp Medicare that would provide the same help in paying for prescription drugs to most of the 40 million people in the nation's insurance program for the elderly, regardless of whether they enter a private health plan, according to an article from the June 10th issue of the Washington Post.

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From the 6/10/03 issue of the Washington Post

House GOP Leaders Agree On Medicare Drug Benefits
By Amy Goldstein and Helen Dewar

House Republican leaders have agreed on the outlines of a plan to revamp Medicare that would provide the same help in paying for prescription drugs to most of the 40 million people in the nation's insurance program for the elderly, regardless of whether they enter a private health plan, according to congressional sources.

The plan by the House GOP leadership, including the chairmen of the two committees that handle Medicare, also would require a small portion of older Americans who are relatively affluent to cover more of their own drug costs -- introducing into Medicare the idea of "means testing" that has proven highly contentious when it has been broached in the past.

The agreement means that House Republicans have joined their Senate colleagues in rejecting a central aspect of changes to Medicare that the White House has sought. President Bush for months has prodded lawmakers to use drug benefits as a powerful inducement for patients to leave the traditional Medicare program, by offering better coverage for medicine to people willing to join a private health plan.

In essence, GOP lawmakers in both houses of Congress now have said that they share the president's goal of expanding the role of private health plans in Medicare in an attempt to save the program money in the long run. But they are reluctant to appear unwilling to give every Medicare patient the drug benefits that are a top priority of older voters -- and a major campaign promise of Republicans.

Medicare is the most expensive and intricate domestic issue remaining before Congress this year. As both chambers plan to take it up in the next few days, the House agreement means that the starting points for debate in the two chambers, while not identical, overlap in key respects, increasing the chances that legislation may be enacted after years of effort.

Details of the House GOP's thinking emerged yesterday as congressional budget analysts finished critiquing a bipartisan Medicare agreement forged last week by leaders of the Senate Finance Committee. That committee is to introduce its legislation this morning and debate it starting Thursday.

According to several Senate sources briefed on preliminary estimates by the Congressional Budget Office (CBO), the drug benefits and other changes to Medicare contemplated by the Finance Committee would have a net cost of $351 billion over 10 years, below the $400 billion limit that both chambers have set for revisions to the program. Sen. John Breaux (La.), a centrist Democrat who has

long pressed his colleagues to modernize the 1965 program, said he and other Finance Committee members would try to use any extra money on more generous benefits to make the program "fairer," especially to people with low incomes.

At the same time, the congressional budgetary advisers have concluded that the changes to Medicare the Senate is considering would have little effect in making private health plans more popular to older Americans.

About 88 percent of the people on Medicare remain in the original fee-for-service form of the program, and the CBO said that perhaps another 2 percent would switch to preferred provider organizations (PPOs) and other private plans. That prediction is far below the Bush administration's estimate that perhaps 30 percent to 40 percent would switch, even without extra drug benefits as an incentive.

Yesterday, Thomas A. Scully, the top administration official who oversees Medicare, said that the low CBO forecast was part of a longstanding dispute between congressional budget analysts and his agency's actuaries over how widespread interest in private health plans would prove.

The Senate bill is being unveiled just days before its House counterpart, which is likely to be considered next week by the Ways and Means Committee and the Energy and Commerce Committee. The House agreement is similar, in several respects, to drug benefits included in Medicare legislation that the chamber has adopted each of the past two years.

Under the new agreement, people who chose to get prescription drug coverage would pay a $35 monthly premium, and a yearly deductible of $250. The government would pay four-fifths of the cost of a patient's medicine, up to $2,000. After that, there would be a gap in coverage before "catastrophic" coverage for patients with extremely large drug bills began.

Under the means-tested part of the plan, which has not previously been adopted by the House, the amount a patient paid before qualifying for the catastrophic benefit would depend on a patient's income.

Most patients would have to pay $3,700 out of their pockets. But the amount would be higher for people with incomes starting at perhaps $50,000 or $60,000 a year.

In addition, a House source said that, while the plan rejects the White House's idea of better benefits, including prescription drug subsidies, for people willing to join private health plans, House Republicans were committed to using other, unspecific methods to try to make such plans attractive.

Yesterday, Health and Human Services Secretary Tommy G. Thompson said as

he left a meeting with GOP members of the Senate Finance Committee that he was not trying at this time to persuade senators to include better drug benefits for patients in private health plans. But he indicated that the administration would still pursue that goal.